OBSTRUCTION OF THE BOWEL BY A LARGE GALL STONE—OPERATION—RECOVERY.

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The following case is of sufficient interest, both on account of its rarity and importance, to bring before this Society.

History: Mrs. H., a widow, aet. 72, rather stout, has never been seriously ill and there is no history of gall-stone colic. Some days ago she slipped and felt something give way in her abdomen; she was fairly well afterwards but always felt as if there was something amiss in the abdomen. On Sunday, February 8th, 1903, after a hearty supper, she went to bed and was awakened Monday morning by an attack of diarrhoea, she had three stools. Soon vomiting came on but no nausea; this continued all day and was without effort, more like regurgitation of intestinal contents. Dr. Gordon Campbell saw her on Monday, purgatives were administered without avail; pulse and temperature normal; no flatus had passed since Sunday. Dr. Campbell, recognizing the case as one of obstruction, called me in Tuesday evening. All that day she had been vomiting and had suffered pain, probably from the purgatives administered. When I saw the patient her pulse was full, 76, temperature normal, no distension, but some tenderness about the umbilical region on pressure. Vomiting was continuous, without effort and was not preceded by nausea. Seeing that there was evidently obstruction due to some unknown cause, I advised an exploratory incision. She was removed to the Montreal General Hospital and operation was commenced at 10.30 p.m. The incision was below the umbilicus and of considerable length because of the stoutness of the patient. On opening the peritoneal cavity and introducing my hand I almost immediately came upon a hard substance within the bowel The bowel was pulled out and it was found that a solid body was wedged into it like a cork. Immediately about it the bowel was dark colored. The contained substance would not be forced on but was easily pushed back, and as soon as healthy bowel was reached an incision was made in the long axis of the bowel, opposite the mesenteric attachment, and the stone removed.

The incision in the bowel was sutured in two layers with silk, first

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the mucous membrane by a continuous suture, and then the outer coats with a continuous silk Lembert's suture. The abdominal wound was closed in layers, the deeper with cat-gut, and the skin brought together with silk-worm gut. The patient went on well and the bowels moved on the second day with an enema. She had no drawbacks and was discharged at the end of three weeks well. I saw her yesterday (March 19th) and she is going about as usual.

The gall-stone measured 10 cm. in its greatest circumference and about 5 cm. in its greatest length. It is of a dark brown color, sinks in water, and on section is made up of concentric layers of soft brown material. It appeared as if it had been pocketted somewhere and that its sharp end had protruded into the bowel, for this was covered by a comparatively fresh layer of faeces; there was a distinct ring where the protruded part apparently was held. It had not the ordinary appearance of a gall-stone. There never was any history of gall-stone colic. The mass had been arrested near the beginning of the ileum, which, as is well known, is smaller than the jejunum.

The fact that it was dislodged by a sudden movement is in favor of this body being a gall-stone; but there was never anything pointing to gall-stone, no colic, malaise, or any inflammatory attack at any time. Mr. Lund (London Lancet, 1896), reports a similar case of an impacted gall-stone without any history of gall-stone colic.

Obstruction from gall-stone is a very fatal affection. Kermisson and Richard, out of 105 collected cases, gave the mortality as 50% (Mayo Robson). Lobstein collected 92 cases, of the 62 cases not operated on 32 recovered and 29 died; of the 31 operated on 12 recovered. Many were moribund at the time of operation (Robson).

It is curious how small a stone has caused obstruction and how large a one has sometimes passed per rectum.

The remarkable thing about the present case is that so large a stone should have ulcerated through the gall bladder into the duodenum without producing any symptoms whatever, not even malaise.

Note.—Since the above was written Professor Ruttan has kindly examined the enterolith for me, and finds that it is undoubtedly a gall-stone, cholesterine being quite easily demonstrated.